Meeting of the SWAG Systemic Anti-Cancer Therapy (SACT) Clinical Advisory Group (CAG)

Friday 22nd March 2024, 15:30-16:30 via MS Teams

Chair: Emma Cattell

	REPORT	ACTIONS

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

2. Review of Previous Notes and Actions

As there were no amendments or comments following distribution of the report from the meeting on Friday 21st October 2022, the report was accepted as finalised.

Actions arising:

To contact the Cancer Alliance Futures online platform to ask for details on the accreditation processes undertaken by UK SACT centres:

The request has been sent via the forum twice, and no responses have been received.

Consultant Medical Oncologist Emma Kipps from the Royal Marsden is Lead of the National SACT Group, which may be the best forum to ask.

Action: To contact Emma Kipps about SACT accreditation processes. **H Dunderdale**

The SACT CAG Leads group convened yesterday and slides had been distributed.

Action: To check the slide set for potential future agenda items. **E Cattell/H Dunderdale**

Impact of NICE TA's to be escalated to the National Cancer Board / to track how the TA funding is being allocated.

In response to feedback from SACT services, the National team have allocated recurrent funds to manage the impact of the recent influx of NICE TA approvals.

UHBW have appointed 2 SACT Advanced Practitioners to Haematology, 1 Breast Cancer Advanced Practitioner, 1 Band 7 Educational Facilitator, 1 Melanoma CNS, 1 Pharmacist post, and some pharmacy support roles using the funding. RUH Bath have also appointed new posts using the funding.

Somerset FT have appointed additional staff to the SACT nursing team and expanded capacity. It is unclear if this funding came directly from the NICE TA funding, and this will be clarified.

Action: Consultant Oncologist Jessica Bailey will be invited to share how the funding has been allocated in Gloucestershire. **H Dunderdale**

Action: Helen Winter will email Sam Killingworth to confirm the funding allocation provided to Somerset FT. **H Winter**

Review of existing Extravasation Policies for development into SWAG Guidance to add to the SWAG website:

There have been some updates made to local Extravasation policies that need to be incorporated into the regional SWAG policy. Advice needs to be sought from the nursing team to ensure that these are aligned, and local contact information is included from all teams.

It may be necessary to keep local policy documents that link with the regional policy due to differences in local provision of Savene.

Action: Lead SACT Nurse's Sally Long and Becca Saunders will review and amend the regional policy and then seek input from Pharmacist Jarrod Dunn. **S Long/B Saunders/J Dunn**

Once a regional Extravasation Policy has been finalised, an Anti-Emetic Regional Policy will be considered.

SACT Capacity and Demand Tools

Action: A separate meeting will be arranged to discuss implementing the MSD capacity and demand tool. **H Dunderdale**

The 6MP adult dosing guidance from BOPA will be published on the SWAG website at the top of the page, along with generic guidance.

In progress.

To ensure equity of access to anti-inflammatory drugs across the region

UHBW are still experiencing problems with accessing Vedolizumab for IO toxicities. It is hoped that national guidance from the British Oncology Pharmacy Association (BOPA) will help get approval for the drug and negate the need for completion of Individual Funding Requests.

Action: SWIG Chair and Immuno-Oncology Clinical Network (IOCN) Representative Claire Barlow will be contacted to see if a statement of support on access to Vedolizumab can be provided by the IOCN. E Cattell

From the agenda:

3. New and updated SACT protocols 2024

Please see the presentation uploaded on to the SWAG website

Presented by Network Pharmacist Kate Gregory

Protocols activity since the last meeting includes development of 11 new protocols, 27 reviewed and amended and a further 23 drafted and awaiting sign off.

The total number of protocols available is 72%. The aim is to increase this, although the rate of NICE TA approvals is currently making this challenging; 17 have been approved since the previous meeting.

A productive Haematology CAG was held recently where a plan was agreed for the related protocols to be drafted and individual Consultants will be contacted to draft the solid tumour protocols. The sarcoma protocols which have been pending for some time are expected to be finalised in the near future.

A new protocol template has been trialled where the order of contents has been changed with hyperlinks added to jump quickly to the various sections. Additional information has also been included, as documented in the presentation.

Feeback to date has been minimal; SACT CAG are asked to provide further comments.

Action: To provide feedback on the new protocol template. SACT CAG

Once feedback has been incorporated into the template, it will be used for the other Myeloma protocols and also considered for the oncology protocols.

The addition of response rates was felt to be useful for trainees, but could sit later in the document.

The vast majority of the time, the protocols are used to make dose adjustments and variations on a day to day basis and this information needs to be the most readily available to the SACT nurses.

SFT day unit nurses have been emailed for further feedback.

It could be possible to make the protocols more interactive in future with help from an IT specialist.

It is important to keep the protocols as concise as possible and not duplicate information available in the Summary of Product Characteristics (SPC), which is updated regularly; a link to SPC guidance could be included instead of the table of drug interactions.

A quick reference to extravasation could also be included but this was not particularly relevant to the DRd protocol.

Overall, the protocol format has improved and is considered better than the Thames Valley format. It will continually be reviewed until considered optimised.

It is thought that the Weston team still prints protocols but there are plans to move to a paperless system.

4. Investigating regional and institutional variation in rates of adjuvant chemotherapy following resection of Stage III colon cancer

The National Cancer Board have undertaken a Treatment Variation Workstream based on data sourced from National Audits. Colorectal CAG has been asked to investigate variation in the rates of adjuvant chemotherapy following Stage III colon cancer.

Data from the SACT audit has been downloaded from the Cancer Stats website on the regimes used for all colorectal cancers; it is not possible to reliably filter this by Stage.

It shows that Capecitabine and Irinotecan are used in Gloucestershire, which differs from other centres.

XELOX and Capecitabine are used most commonly across the board.

It is hoped that looking at the data prior to the National Treatment Variation Workshop may help address any queries.

The data needs to be interpreted very cautiously due to the number of variables that alter patient management such as age, frailty, stage, etc. for the subsequent treatment to be taken in context.

There were some non-colorectal (prostate) regimens included in the data, which does not give confidence in the accuracy of the data collection. This could be due to a secondary diagnosis of prostate cancer.

Action: To investigate how non-colorectal regimens are linked to patients with a colorectal cancer diagnosis.	**SACT Audit Managers**

The catchment population would also be useful to know as it appeared that Gloucestershire were treating far more patients than the other SWAG Trusts.

While the data is not able to be used to determine how well a Trust is doing (although it was important to note that there was a lot of consistency in the regimens most widely used across all Trusts) it may be useful to direct where detailed audits could be useful.

XELOX should be renamed as CAPOX in the SACT audit and XELIRI should be renamed CAPIRI.

It is important to find the number of patients receiving adjuvant treatment across the region to predict screening numbers for the Cancer Vaccine trial.

National scrutiny of the data is expected to increase over the next few years and it would be useful to look at in more detail.

Attempts to filter the data by treatment intent had shown that the resulting data export looked significantly inaccurate.

The National audit combines datasets, but it is not possible to look at this via the Cancer Stats website.

Investment needs to be made in data management to improve data quality. Data analysts often need to source the information from multiple different systems and some fields can be challenging to find.

Action: SACT CAG to look at chemotherapy given to patients in different age groups at a future meeting.	**To be allocated**

5. Subcutaneous IO and impact on SACT Delivery

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Medical Oncologist Helen Winter

There needs to be a collaborative approach to improve delivery of SACT by sharing best practice, education, and innovations.

Ideas include:

- Streamlining treatment options, for example, switching from 5FU to capecitabine, which appears to have been achieved in most centres
- Moving from inpatient to outpatient regimens, for example with provision of BEP for teenagers and young adults
- Moving to ambulatory care for autografts
- Simplify and accelerate delivery of subcutaneous atezolizumab as opposed to intravenous delivery, which reduces administration time from one hour to 7 minutes, although only for a small group of patients
- Moving subcutaneous delivery of SACT from the SACT day unit to outpatient clinics
- Extending the intervals between therapies, for example, 3 to 6 weekly immunotherapies.

A recent exemplar of sharing best practice was demonstrated when a regional webinar was held on IDH-1 in the same week that a related NICE TA was approved.

Additional shared resources, such as the extravasation policy and management of toxicity guidelines could be produced.

The ACCEND workforce initiative to upskill the workforce and other educational forums, such as the IO forum, will be promoted.

Another upcoming initiative is implementation of circulating tumour DNA (ctDNA) tests for lung cancer patients. SWAG has taken part in a pilot, and it is soon expected to be made standard care to ensure all patients with actionable mutations can receive oral targeted treatments.

The ambition of SACT CAG is to make these available as early after diagnosis as possible; 48 hours has been suggested or within 5 days.

Any further ideas or feedback on driving faster SACT treatments are welcomed from the group.

Discussion:

SFT have commenced subcutaneous atezolizumab, but this has had an impact on capacity as it requires 3 weekly treatments rather than the 4 weekly IV infusion. Most patients prefer the 4 weekly option, which can be given in 30 minutes by Home Care. The sub-cut option is mostly used for patients where there are issues with cannulation or for patients who are already receiving additional 3 weekly drugs.

BHOC currently do not have a Home Care service so giving atezolizumab subcutaneously (which has commenced in part) could save chair time. Waiting times in BHOC was 4-5 weeks at some point but have now been reduced.

It is not practical for the patient to self-administer as it needs to be given over a 7 minute period.

Another pathway being trialled in the South West is administration of subcutaneous SACT by community pharmacists.

6. Daratumumab observation period

Please see the presentation uploaded on to the SWAG website

Presented by Lead SACT Nurse Sally Long

Current SWAG guidelines recommend a 6 hour observation period post first sub-cut injection of Daratumumab, however, the SACT nurses on the Chemotherapy Day Unit had not perceived that this was necessary.

A retrospective audit was undertaken which identified 70 new patients over the past 3 years. Data collection was completed on 62 of these patients, 5 of which had a reaction to the drug; 1 patient reacted within 1 hour, 2 patients within 3 hours and 2 patients had a reaction after the 6 hour observation period when they had been discharged home. The data was put to the myeloma team who requested further information prior to deciding if the observation period could be reduced. It was noted that Thames Valley, Clatterbridge and Southampton protocols recommend a 4 hour observation period.

SFT contacted Janssen who confirmed that the average time for a severe reaction is within 3 hours and so this had been extrapolated and a 4 hour observation period agreed into practice approximately 6 months ago. No incidences have been recorded to date.

Action: The information from Janssen and from an additional audit of Daratumumab undertaken in SFT will be shared and taken to the next SACT group. J Dunn

Action: To find out what other SACT centres are doing. H Dunderdale

7. Electronic Consent Process at RUH Bath

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Medical Oncologist Sharath Gangadhara

Most centres are using the Cancer Research UK paper consent forms, but only RUH is using the e-Consent forms at present.

SACT CAG agree that the consent process is becoming increasingly complex.

E-consent has commenced as a trial in RUH for colorectal and lung cancer patients. This has been found to be practical to implement, with the e-consent portal being accessible in one click from within the patient record.

Once logged into the portal using your computer login, you click 'create new', use the filter function to select the correct consent form and select the treatment intent. It will then auto select all risks, which can be unticked if they do not apply (fertility for example). There is a free text box if you want to include any additional information. Macmillan patient information sheets are also automatically attached.

Once complete, it is signed by the Clinician who, when using for the first time, needs to create a signature using an e-signature creating device (as displayed in the presentation) or by carefully drawing with the computer mouse; it will be stored for future use.

The existing document can then be emailed to the patient so that they can read and sign in their own time. If the regimen needs to change when in a telephone clinic, the consent form can be updated and resent.

The patient can then sign using their mobile device.

Final confirmation of consent will be signed by the pharmacist if dispensing oral SACT, or on the day of treatment by the SACT Nurse if having IV SACT.

Once all parties have signed, the finalised document is saved to the patient record and viewable to everyone. This speeds up the consent process as it auto-populates with the patient information and does not involve printing sticky labels.

The challenge is double checking that the consent forms are completely up to date; current governance arrangements are to proof read the forms every 6 months. CRUK will let centres know when any changes occur to the forms; reviews and updates are usually made every 2 years.

The consent forms are in the process of being proof read to see if they can be rolled out to additional cancer sites.

Discussion:

The consent forms need to be amended for IO as the time period for the cycles always needs to be adjusted. It is thought that SWIG Chair Claire Barlow is assisting CRUK with their development.

CRUK are open to taking feedback and amending the forms as and when appropriate.

The platform used by RUH had been developed by the team in Liverpool and works with the Millennium Hospitals Information System.

Action: A link to the portal will be shared. **S Gangadhara**

Action: The Cancer Alliance will be contacted to see if funding could be made available to implement e-consent across the region, with the intention of also improving earlier access to treatments. **H Dunderdale**

Date of next meeting: Friday 18th October 2024, 15:30-17:00 via MS Teams

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